



Paramount Care of Michigan, Inc.—2009

The following is our Annual Statement to Subscribers, a yearly update that describes our services, provider networks, complaint procedures, and member rights and responsibilities.

Paramount Care, Inc., was licensed in Ohio in 1988. A separate corporation, Paramount Care of Michigan, Inc., was established and received Michigan licensure in June 1996 to serve customers in Michigan. Paramount is a for-profit entity and is wholly owned by ProMedica Health System, a nonprofit entity. ProMedica serves its communities through five divisions—ProMedica Ambulatory and Acute Care; ProMedica Physician Group; ProMedica Health, Education and Research Corporation; ProMedica Continuing Care Services Corporation; and ProMedica Insurance Corporation.

Paramount is a health maintenance organization (HMO). As of December 31, 2008, our commercial member enrollment is approximately 83,440 in Ohio and 5,807 in Michigan. On December 1, 1998, Paramount's Medicare Risk product, Paramount Elite, was approved by HCFA to enroll eligible Medicare beneficiaries living in Monroe County, Mich. At the end of 2008, there were approximately 1,116 Paramount Elite members.

Paramount offers a variety of comprehensive health benefit plans for our members. Paramount's participating Primary Care and Specialist Physicians treat Paramount members in their own private offices conveniently located throughout the area. A current directory of Participating Physicians and Facilities lists the Primary Care Physicians (Family Practice, Internal Medicine, or Pediatrics) and participating specialists and hospitals. If you would like to receive a current version of the Participating Physicians and Facilities directory, call Member Services at **1-734-529-7800** or outside the area at **1-888-241-5604**. Or you can visit the Paramount Web site at www.paramountcareofmichigan.com to find a list of participating providers.

The Paramount service area in Michigan includes Lenawee and Monroe counties. In Ohio, the service area includes all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot and portions of Allen, Delaware, Hardin, Knox, Lorain, and Paulding counties.





The Paramount Care of Michigan, Inc., administrative office is located at:

106 Park Place

Dundee, MI 48131-1016

Telephone: 1-734-529-7800

Toll-free: 1-888-241-5604

Member Services Call Center hours:

8 a.m. to 5 p.m., Monday through Friday

Paramount contracts with providers for health care services on an economically competitive basis, while taking steps to ensure that all our members receive appropriate and timely access to qualified providers. Through contracts with participating providers, Paramount obtains discounts. These discounts help Paramount offer affordable premiums. When copayments are charged as a percentage of eligible expenses, the amount you pay is determined as a percentage of the allowed charge between Paramount and the participating provider rather than a percentage of the provider's billed charge. Paramount's allowed charge is ordinarily lower than the participating provider's billed charge. Therefore, the benefit of the discount is passed on to you.

Express Scripts provides Pharmacy Benefit Management (PBM) services for Paramount. Part of this service is to obtain discounts at pharmacies that contract with Express Scripts. These discounts are passed on to you. If your drug copayment is a percentage, the amount you pay is determined as a percentage of the cost, rather than a percentage of the retail cost. Therefore, the benefit of the discount is passed on to you. If the drug costs less than your copayment, you will pay the lesser of your copayment or the discounted cost of the drug plus the pharmacist's dispensing fee. Under our agreement with Express Scripts, there are also certain administrative costs and rebates. Neither the administrative costs nor the rebates are

included in your drug benefit. Paramount pays the administrative costs and retains the rebates to help offset administrative expenses. Not all benefit plans, however, include coverage for outpatient prescription drugs. Contact the Member Service Department if you have questions.

Physicians who apply to participate must meet high standards established by their peers and approved by the Board of Directors. Paramount physicians actively participate in our managed care programs. Except for deductibles, copayments, and noncovered services, participating providers may not bill members for covered services.

Current quality improvement activities include promotion of preventive services and improved care for people with chronic illness. Examples include monitoring diabetes, asthma, pediatric immunizations, and stop-smoking programs. In addition, our member newsletter offers constructive information to encourage effective use of Paramount services. Direct member surveys also monitor member satisfaction.

How to Handle a Problem or a Grievance

What to Do When You Have Questions, Problems, or Grievances

Paramount's Member Service Department welcomes your questions from 8 a.m. to 5 p.m., Monday through Friday. The Member Service staff can be reached by calling **1-734-529-7800** or toll-free **1-888-241-5604**. You can contact us by e-mail at member.services@promedica.org.

If you call the Member Service Department after hours, you can leave a message, and you will receive a return call on the next working day.

The Member Service Department's goal is to help you with any questions about procedures, benefits, payment for services, enrollment, and more. We encourage you to call us with any questions. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits, please write us, call us, or send us an e-mail.

How to Handle a Problem or a Grievance

A problem or grievance is when you are dissatisfied with any aspect of Paramount's service. If you have a problem with one of Paramount's providers, we encourage you to first discuss the issue with the provider. If the issue cannot be resolved, call the Member Service Department. You can call or write

the Member Service Department about a problem. A Member Service Representative will attempt to resolve the problem or grievance informally. If we are not able to resolve the problem or grievance to your satisfaction, you can appeal. The total grievance process will take **no longer than thirty-five (35) calendar days** after a formal grievance is submitted. The 35 calendar days do not include whatever reasonable time the member takes to prepare his or her response and **no more than ten (10) additional business days** if Paramount has requested information from a health provider or health care facility and has not received the information.

Under Michigan Public Act 252, a “grievance” means a complaint by the member concerning any of the following:

- A. The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination (denial) made by utilization review
- B. Benefits or claims payment, handling, or reimbursement for health care services
- C. Matters concerning the contractual relationship between a member and Paramount

Under Michigan Public Act 252, an “adverse determination” means a determination by Paramount that an admission, availability of care, continued stay, or other health care service has been reviewed and has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

For problems or grievances, you should follow the steps outlined below:

(Appeal rights vary for members of self-insured and FEHB groups. Refer to your summary plan description or benefit booklet.)

Internal Grievance—Level 1

If you have a problem, call or write the Member Service Department. A Member Service Representative will try to resolve the problem or grievance **within two (2) working days** for urgent clinical issues and **seven (7) calendar days** for other problems. You will be advised of the disposition of your problem or grievance by telephone or in writing. If the first-level problem or grievance is not resolved to your satisfaction, you can appeal to Paramount verbally or in writing.

Internal Grievance—Level 2

If the first-level problem or grievance is not resolved to your satisfaction, you will be informed of your right to file a verbal or written second-level grievance with

Paramount. A written grievance should be sent to the address below.

Paramount Care of Michigan, Inc.
Member Service Department
106 Park Place
Dundee, MI 48131-1016
Telephone: 1-734-529-7800
Toll-free: 1-888-241-5604

You must request an internal review **within two (2) years** from the denial, reduction, or termination of benefits. You will receive an acknowledgment from Paramount **within five (5) working days** from receipt of your request. You will also be advised that you have the right to attend an informal hearing to present your appeal in person to the Internal Grievance Committee. The member may authorize in writing that any person, including but not limited to a physician, may act on his or her behalf at any stage in the internal review.

If the service is being denied, reduced, or terminated because of contract benefit limits, because the service is not covered under the contract, or the case involves a membership or enrollment issue, the review will be conducted by the Internal Grievance Committee. Paramount will consult a clinical peer for this review if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service or provide treatment. The clinical peer will review your medical records and determine if the service is medically necessary.

Paramount must provide you with a written response indicating its decision **within thirty-five (35) calendar days** of the date we receive your request for an internal review. The 35 calendar days do not include whatever reasonable time the member takes to prepare his or her response and **no more than ten (10) additional business days** if Paramount has not received requested information from a health provider or health care facility.

If your medical condition requires a faster review (called an expedited internal review), Paramount must provide you with a response **within seventy-two (72) hours**. An expedited internal review applies if a grievance is submitted and a physician verbally or in writing verifies that the time frame for a standard internal review would seriously jeopardize the life and health of the member or would jeopardize the member’s ability to regain maximum functioning. If you wish to request an expedited internal review, you can call the Paramount office at **1-888-887-5101** or send a fax to **1-888-740-0222**.

If Paramount does not issue a written decision to you or your authorized representative **within thirty-five (35) calendar days** for an internal review or **within seventy-two (72) hours** for an expedited internal review, it is considered a denial, and you have the right to request an external review with the Office of Financial and Insurance Regulation (OFIR) Health Plans Division and shall be considered to have exhausted Paramount's internal grievance process.

Additional Appeals

If Paramount denies your internal grievance (issues a final adverse determination), you will be informed of your right to ask the OFIR for an external independent review. Forms required to request an external review will be made available to you by Paramount and are available at the OFIR Web site. Go to www.michigan.gov/cis and click on "Financial & Insurance Regulation" on the left.

The address is:

**Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P.O. Box 30220
Lansing, MI 48909-7720
Telephone: 1-877-999-6442**

Instructions for Requesting an External Independent Review

Not later than sixty (60) days after the date you receive a notice of an adverse determination or final adverse determination, you or your authorized representative can file a request for an external review with the OFIR. If you request an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If the OFIR accepts the request for an external independent review, you will receive an acknowledgment from the OFIR. (If the OFIR does not accept the request, the OFIR will notify you of the reason.) The OFIR will select a state-approved independent review organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify the OFIR of its recommendation. The OFIR will then review the recommendation and notify the member and Paramount of the OFIR decision.

Expedited External Reviews

You or your authorized representative can make a request for an expedited external independent review with the OFIR **within ten (10) days** after receiving an adverse determination if both of the following are met:

- ▶ The adverse determination involves a medical condition in which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function as substantiated by a physician either verbally or in writing.
- ▶ The member or member's authorized representative has filed a request for an expedited internal grievance.

Denials on services that have already been received do not qualify for an expedited external review. If the OFIR accepts the request for an expedited external independent review, you will receive an acknowledgment from the OFIR. The OFIR will select a state-approved IRO to conduct the expedited external review. The IRO will review all pertinent records available and notify the OFIR of its recommendation. You will receive a final decision from the OFIR **within seventy-two (72) hours** from receipt of your request for an expedited external review.

You may not bring action in court against Paramount until you have exhausted all the applicable procedures described above.

Members' Rights

As a member of Paramount, you are entitled to receive certain rights from Paramount and Paramount providers. You have the right to:

- ▶ Receive information about Paramount, its services, providers, and your rights and responsibilities
- ▶ Participate with your physicians in decision making regarding your health care
- ▶ Have a candid discussion of appropriate or medically necessary treatment options for the conditions regardless of cost or benefit coverage
- ▶ Voice complaints or appeals about Paramount or the care provided
- ▶ Be treated with respect, recognition of your dignity, and the need for privacy
- ▶ Make recommendations regarding the organization's member rights and responsibilities policies

Members' Responsibilities

As a member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

- ▶ Provide, to the extent possible, information that Paramount and participating practitioners need in order to care for you

- ▶ Engage in a healthy lifestyle, become involved in your health care, and follow the plans and instructions of care that you have agreed on with your Primary Care Physician or specialists
- ▶ Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible

Insurance Fraud

Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please call the Paramount Member Service Department for confidential handling at **1-734-529-7800** or toll-free at **1-888-241-5604**. TTY services for the hearing impaired are available at **1-419-887-2526** or toll-free at **1-888-740-5670**. You can also call the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is **1-419-824-1815** or toll-free **1-800-807-2693**.

Paramount Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW YOUR NON-PUBLIC PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE COLLECTED, USED, AND DISCLOSED BY US AND HOW YOU CAN GET ACCESS TO THE INFORMATION WE HAVE ABOUT YOU; PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to the following affiliated covered entities: Paramount Health Care; Paramount Care of Michigan, Inc.; and Paramount Insurance Company (collectively Paramount) operating as health plans to carry out payment and health care operations as permitted by law.

II. WE HAVE A LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION.

We are required by law to protect the privacy of your health information. This includes all non-public personal information about you, such as whether you are enrolled in a Paramount health benefits plan, your premium information, and your claims information. We are required to provide you with this notice about our privacy practices. We are required to comply with all of the terms described in the current version of our Notice of Privacy Practices. You can request a copy of this notice from the contact office listed in Section X at any time and can view a copy of this notice on

our Web site at www.paramounthealthcare.com or www.paramountcareofmichigan.com.

III. HOW WE COLLECT INFORMATION

We collect information about you that is related to your participation in a Paramount health benefits plan. We receive information from you on applications and other forms that you submit to us and from your transactions with us, our affiliates in the ProMedica Health System, or others.

IV. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

A. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

Paramount collects health information from you and stores it in a paper file and on computer. Except as outlined below, we will not use or give out information about you for any purpose unless you have signed an authorization form.

1. **To carry out payment.** When you enroll with Paramount, we may disclose information about you to carry out payment functions. For example, we may use information about you for the purpose of:
 - ▶ Claims payment
 - ▶ Collection of premiums
 - ▶ Coordination of benefits
 - ▶ Subrogation of health benefit claims
2. **For regular health plan operations.** When you enroll with Paramount, we may disclose information about you to operate this health plan. For example, we may use information about you for the purpose of:
 - ▶ Referrals, precertification, and case management
 - ▶ Distribution of disease management educational notices and preventive care reminders
 - ▶ Quality assessment and improvement activities
 - ▶ Medical review and auditing functions, including fraud and abuse detection
 - ▶ Underwriting and premium rating
 - ▶ Customer service and requests for internal reviews
 - ▶ Accreditation activities and program licensure

In addition, we give your information to our business associates, such as a pharmacy benefit manager and others, who process our claims. We may also provide

information about you to our accountants, attorneys, consultants, and others in order to make sure that we are complying with the laws that affect us.

3. **When required by federal, state, or local law; judicial or administrative proceedings; or law enforcement.** For example, we give out your information when the law requires that we report information to government agencies and law enforcement personnel in response to a subpoena, when ordered by the court, or in response to a discovery request.
4. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or audit to determine beneficiary eligibility and compliance with program standards.
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may give your information to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** We may give out information on military personnel and veterans in certain situations. We may give your information to correctional institutions and law enforcement in custodial situations. We may also give your information for national security or intelligence activities.
7. **For workers' compensation purposes.** We may give out your information in order to comply with workers' compensation laws.
8. **To family and friends involved in your care.** If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with family, friends, or others who are involved in your care or in payment for your care.

B. DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Before we use or disclose your personal health information for any reason other than those reasons listed in Section IV.A, we will need to get your written authorization. If you authorize us to use or disclose your information, you can revoke your authorization by notifying the office listed in Section X in writing.

V. YOUR HEALTH INFORMATION RIGHTS

A. THE RIGHT TO REQUEST LIMITS ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

You have the right to ask that we limit how we use and give out your information. We will carefully consider your request but are not required to accept it. If we accept your request, we will put it in writing and abide by it.

B. THE RIGHT TO CHOOSE HOW WE SEND YOUR INFORMATION TO YOU

You have the right to ask that we send information to you at an alternate address. For example, you may ask us to send information to your work address rather than your home address. You can also ask that it be sent by alternate means. For example, you can ask that we send information by fax instead of regular mail. We will agree to your request if we can easily provide it in the format you request.

C. THE RIGHT TO SEE AND GET COPIES OF YOUR HEALTH INFORMATION

Most of the time, you have the right to look at or get copies of your health information that we have. Your request must be on the appropriate form and signed by you or your legally authorized representative. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons why and explain how you can have the denial reviewed.

D. THE RIGHT TO GET A LIST OF WHOM WE HAVE GIVEN YOUR INFORMATION TO

You have the right to get a list of certain instances in which we have given out your health information after April 14, 2003.

E. THE RIGHT TO CORRECT OR UPDATE YOUR HEALTH INFORMATION

If you believe that there is a mistake in your information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing



information. Your request and your reason for the request must be submitted on the appropriate form. Each request will be carefully considered. If we approve your request, we will make the change to your information, tell you that we have done it, and tell others who need to know about the change.

F. HOW TO MAKE REQUESTS

To make requests under Sections V.A through V.E, complete the appropriate form available from the contact office listed in Section X and send it to the address indicated.

G. THE RIGHT TO GET THIS NOTICE

You have the right to get a copy of this notice by e-mail. You also have the right to request a paper copy of this notice.

VI. PROCEDURES TO MAINTAIN CONFIDENTIALITY AND SECURITY

Paramount restricts access to health information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with applicable law.

VII. CHANGES TO THE POLICY

If our privacy policy should change at any time in the future, we will promptly change, post, and distribute the new notice. We will also distribute this Notice of Privacy Practices annually. We reserve the right to apply any changes to our privacy policy or this notice to all of the personal health information that we maintain, including information collected before the date of the change.

VIII. COMPLAINTS

If you think that we may have violated your privacy rights or you disagree with a decision we made about your health information, you may file a complaint with the office listed in Section X. You may also send a written complaint to the Secretary of the Department of Health and Human Services in Washington, D.C. We will take no action against you if you file a complaint about our privacy practices.

IX. PROTECTIONS APPLY TO FORMER MEMBERS

Paramount does not destroy information about you when you terminate your coverage with us. However, the policies and procedures outlined in this notice continue to apply to protect the information of former members.

X. OFFICE TO CONTACT FOR INFORMATION ABOUT THIS NOTICE

If you have any questions about this notice or any complaints about our privacy practices, please contact:

Paramount Member Service Department
1901 Indian Wood Circle
Maumee, OH 43537
Mailing Address:
P.O. Box 928
Toledo, OH 43697-0928
Telephone: 1-419-887-2525
Toll-free: 1-800-462-3589

XI. EFFECTIVE DATE OF THIS NOTICE

This notice goes into effect on April 14, 2003.

To the extent state privacy laws apply, these state laws (rather than the terms of this notice) might impose the privacy standard under which Paramount is required to operate.

Paramount Web Site

Visit our Web site at www.paramountcareofmichigan.com. Through the Web site, you can access your health plan information, the Provider Directory, Frequently Asked Questions (FAQs), health tips, news articles, the Preferred Drug List, and more. You can also e-mail Paramount with your questions. Check us out!

Go to www.paramounthealthcare.com/myaccount to complete an interactive evaluation of your health. You need your Paramount ID number to register first. Visit Paramount's online health information resource today for access to 3,000 health topics!

Board of Directors

The Paramount Care of Michigan, Inc., Board includes Chairperson John C. Randolph; Randy Oostra; Kent Bishop, M.D.; and Thomas P. Cox, M.D. The subscriber representatives to the Board are Thomas M. Sexton and Richard A. Wasserman.

The Board of Directors meets quarterly to oversee business related to Paramount Care of Michigan, Inc. The Board of Directors can be contacted by sending a letter to the Paramount Care of Michigan, Inc., administrative office to the attention of the Board of Directors.

**Important
Women's Health and Cancer Rights Act of 1998
Annual Notice for 2009**

This notice is being sent to you in accordance with H.R. 4328, the Women's Health and Cancer Rights Act of 1998, passed by Congress and signed by President Clinton on October 21, 1998.

The act amends the Employee Retirement Income Security Act of 1974 to require group health insurers that provide "medical and surgical benefits with respect to a mastectomy" to also cover the following:

A member who will be receiving or has received a mastectomy and who elects breast reconstruction in consultation with her physician will have coverage for:

- ▶ Reconstruction of the breast on which the mastectomy has been performed,
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- ▶ Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be subject to the same office visit copayments and/or coinsurance (if any) described in your Summary of Benefits as are applicable to other covered services.

Paramount is proud of the fact that we provided the above coverage to our members before it was required by legislation. However, this annual notice is required as part of the law. If you have any questions, please call the Member Service Department at **1-734-529-7800** or toll-free at **1-888-241-5604**.



www.paramountcareofmichigan.com

